STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
DIVISION OF LONG TERM CARE

State Copy _____
County Copy _____
County:

APPENDIX H TO 2013 STATE AND COUNTY CONTRACT
FOR SOCIAL SERVICES AND COMMUNITY PROGRAMS

Appendix Title: Medicaid Community Waivers:
Community Options Program Waiver (COP-W)–Profiles 337, 338 and 339
Community Integration Program II (CIP II)–Profiles 347, 348 and 349
Community Integration Program II Family Care Transfer – profiles 391,392,393
Community Relocation Initiative–CIP II (CRI) Profiles 368, 369 and 370
Community Integration Program–Nursing Home Diversions-Profiles 374, 375, and 376

I. Funds Provided/Period Covered

Funds in the amount identified in this contract are provided for the period beginning January 1, 2013 through December 31, 2013.

II. Purpose and Service Conditions on the Use of the Additional Funds:
These additional funds may be used by the County only in accordance with section 46.27(11) and 46.277 of the Wisconsin Statutes, the Department MA Waivers Manual, numbered COP information bulletins, DDES (DLTC) Numbered Memos, and the 2013 County Community Options Plan which are by reference made part of this contract. The funds shall be apportioned as follows:

COP-Waiver (Profiles 337,338 & 339)

CARS Profile 337 is a reporting profile for all allowable COP-Waiver expenses.
The County shall report 100% of allowable COP-W expenses on CARS Profile 337. The CARS system will allocate and pay reported expenses on CARS profile **338** (non-federal share) and CARS profile **339** (federal share) according to the "approved Federal Medical Assistance Percentage (FMAP) rate". The Federal matching rate in effect is the Federal Medical Assistance Percentages (FMAP) finalized and published in the Federal Register. The matching rate is calculated annually. The FMAP for the current federal fiscal year can be found on the Federal Register Website (www.federalregister.gov)

Sub-Allocation A: COP-W State Share matching Funds (**Profile 338)**
COP-W State Medicaid GPR matching funds are allocated for reimbursement for the non-federal portion of COP-W allowable service costs. This amount can be increased or decreased at any time during the contract period, by letter from the Wisconsin Department of Health and Family Services. The CARS Profile 338 is contract controlled. The non-federal share of allowable COP-W expenses that exceed the COP-W GPR contract amount will roll to the county base allocation (Profile 561) for payment.

Sub-Allocation B: COP-W Federal Funds **(Profile 339)**
COP-W Medicaid federal funds are available to reimburse counties at the Federal Fiscal Medical Assistance Percentage (FMAP) rate for allowable COP-W service costs. Federal matching funds are earned as the state share is expended. The federal share of expenses will be reimbursed completely, provided the County has matching non-federal funds. The amount of federal funds shown on CARS is an approximate amount of federal funds that may be earned based on a **blended calendar FMAP rate of 59.27%.** The actual amount

of federal funds reimbursed to a county is determined by the FMAP rate in effect at the time reported expenses are paid by the CARS system. The Federal matching rate in effect means the federal Medical Assistance percentages that are finalized and published on the Federal Register website (www.federalregister.gov)

By letter notice from the Department, the GPR funds allocated for the COP-Waiver may be earmarked by the Department for purposes of achieving significant proportion compliance for under-served target groups under ss.46.27 (3)(e) 1, or for compliance with care management standards under ss.46.27 (6d), or in accordance with other policies developed by the Department.

CIP II (Profiles 347,348, & 349)

CARS Profile 347 is a reporting profile for all allowable CIP II expenses.
The County shall report 100% of allowable CIP II expenses on CARS Profile 347. CARS profile 347 will allocate and pay reported expenses on CARS profile **348** (non-federal share) and CARS profile **349** (federal share) according to approved Federal Medical Assistance Percentage (FMAP) rate. The Federal matching rate in effect means the federal Medical Assistance percentages that are finalized and published in the federal register. The federal government uses state per capita personal income to calculate each state's reimbursement rate for Medicaid and other grant programs. The matching rate, calculated annually, is known as the FMAP. The FMAP for the current federal fiscal year can be found on the Federal Register website, www.federalregister.gov.

CIP II: Non Federal Share of Reported Expenses **(Profile 348)**
CIP II state Medicaid funds are available to reimburse counties for 100% of allowable CIP II non-federal share of service costs up to a maximum approved average daily rate. By letter notice the Department may increase or decrease the number of CIP II slots/funding allocated to the County. By letter notice the Department may increase the allowable average daily rate. The contract amount is developed based on the calculation of the number of CIP II regular slots times 365 days of service, times the average daily rate of $41.86 per day, times the approved state/federal ratio. The CIP II allocation is increased with funding earned through the CRI program prior to June 30, 2009. The calculations included in the contract amount used a blended ratio of 40.74**%** non federal and **59.27%** federal.

Reimbursement of funds is based on actual expenses incurred during the calendar year. The non-federal share of CIP II expenses is contract controlled. Under the current process, the non-federal share of costs that exceed the contract amount will roll to CARS profile 561, the basic County allocation (BCA) for payment. If a County chooses to use COP to offset this overage, a manual adjustment must be made to reduce the charge to the BCA and charge profile 367 for COP. A county must notify the Department of the intent to use COP dollars for this overage at close of year's activity.

DDES (DLTC) Memo Series 2006-03 will allow Counties to manage the CIP II funds as an allocation. Counties will be allowed to serve as many people as possible within their CIP II allocation and will not be required to receive a formal per diem rate variance from the Department as long as the combined average per diem, (including administration) of a county's COP-W and CIP II expenditures does not exceed the CIP II per diem (currently $41.86). Because of federal waiver requirements, counties that exceed this per diem require a variance from the Department, as discussed in the Medicaid Waiver Manual.

The Department reserves the right to transfer cases between CIP II and COP-Waiver in order to maximize revenues available to the County. The Department may reimburse CIP II waiver expenses exceeding the contract maximum if sufficient dollars are available in the CIP II waiver statewide, or if a CIP II rate variance is approved for the County. Advances will be based upon the projected cost over the year for the anticipated caseload during the first quarter of the year.

CIP II: Federal Share of Reported Expenses **(Profile 349)**
CIP II federal Medicaid funds are available to reimburse counties for 100% of the allowable federal share of the CIP II service costs up to a maximum approved average daily rate. By letter notice the Department may increase or decrease the number of CIP II slots/days allocated to the County. By letter notice the Department may increase the allowable average daily rate. The contract amount is based on the calculation of regular CIP II slots times 365 days of service, times the average daily rate of $41.86 per day, times the approved state/federal ratio. The calculations included in the contract amount used a blended ratio of **40.74%% %** non-federal and **59.27%** federal. Reimbursement of funds is based on actual expenses incurred during the calendar year. The federal portion of reported costs will be reimbursed for all waiver-allowable costs provided the County has identified matching non-federal funds.

The Department reserves the right to transfer cases between CIP II and COP-Waiver in order to maximize revenues available to the County. The Department may reimburse CIP II waiver expenses exceeding the contract maximum if sufficient dollars are available in the CIP II waiver statewide, or if a CIP II rate variance is approved for the County. Advances will be based upon the projected cost over the year for the anticipated caseload during the first quarter of the year.

DDES (DLTC) Memo Series 2006-03 will allow Counties to manage the CIP II funds as an allocation. Counties will be allowed to serve as many people as possible within their CIP II allocation and will not be required to receive a formal per diem rate variance from the Department as long as the combined average per diem, (including administration) of a county's COP-W and CIP II expenditures does not exceed the CIP II per diem (currently $41.86). Because of federal waiver requirements, counties that exceed this per diem require a variance from the Department, as discussed in the Medicaid Waiver Manual.

Initial contract amounts for the CIP II program **do not include** funding for participants who have moved from a Family Care County to a waiver count. Funding specific to these individuals will be contracted through a separate contract amendment. All conditions identified in this contract for CIP II regular are applicable to the CIP II family care transfer funding (CIP II-FCT) (**profiles 391,392, and 393**). CIP II Family Care transfer financial and functional eligibility is the same as the regular CIP II – this is a subset of the CIP II regular and differs only in that the funding is person specific and is based on the actual plan and service costs for that person.

CIP II-Community Relocation Initiative (CRI) (Profiles 368, 369, 370)
CRI funds will modify and expand the current CIP II program waiver for elders and persons with physical disabilities and will enable the Department to provide enhanced funding above the standard CIP II waiver rate to reflect the actual cost of the waiver care plan. The total number of people served under the program statewide can not exceed the number of beds closed statewide. There is no requirement that the resident's bed or any other bed in the facility be closed under this program. Funding earned through the CRI program prior to June 30, 2011 will become a part of the Counties CIP II regular funds and separate tracking will no longer be required by a County. Permanent funding is earned

when an individual has been a CRI participant for 180 days or more. Eligible CRI funding will initially be transferred to the County's CIP II base through a separate contract amendment.

CARS Profile 368 is a reporting profile for all allowable CIP II-CRI expenses
The County shall report 100% of allowable CIP II-CRI on CARS Profile 368. CARS profile 368 will allocate and pay reported expenses on CARS profile **369** (non-federal share) and CARS profile **370** (federal share) according to current Federal Medical Assistance Percentage (FMAP) rate. All expenses incurred for persons who have been relocated from a nursing home and for whom special CIP II (CRI) funding was approved must be reported on CARS profile 368.

CIP II-CRI: Non Federal share of Reported Expenses **(Profile 369)**
CIP II-CRI state Medicaid funds are available to reimburse counties for 100% of the allowable State's share of service costs for persons who have been relocated from a nursing home if Medicaid is currently paying for their nursing home care. By letter notice the Department may increase or decrease the number of CIP II-CRI relocations allocated to the County. By letter notice the Department may increase the allowable care plan costs. The above amount is based on the calculation of the number of people relocated, times 365 service days, times each person's care plan cost per day, times the current state/federal ratio. The calculations included in the contract amount used a blended ratio of **40.74%** non-federal and **59.27%** federal.

Reimbursement of funds is based on actual expenses incurred during the calendar year. The non-federal share of CIP II-CRI expenses is contract controlled. Under the current process, the non-federal share of costs that exceed the contract amount will roll to CARS profile 561, the basic County allocation (BCA) for payment. The Department may reimburse CRI waiver expenses exceeding the contract maximum if sufficient dollars are available in the CRI waiver statewide. COP regular funding **may not** be used to pay for expenses in excess of the CRI non federal contract amount. The conditions identified above apply only to the funding identified with this profile.

CIP II-CRI: Federal Share of Reported Expenses **(Profile 370)**
CIP II federal Medicaid funds are available to reimburse counties for 100% of the allowable federal share of the CRI service costs. By letter notice the Department may increase or decrease the number of CRI relocations allocated to the County. By letter notice the Department may increase the allowable care plan per diem for individuals. The above amount is based on the calculation of x relocations times 365 days of service, times the average daily rate per day for each individual, times the approved state/federal ratio. Reimbursement of funds is based on actual expenses incurred during the calendar year. The federal portion of reported expenses may be reimbursed for waiver-allowable costs that exceed the approved care plan daily rate, provided there are sufficient non-federal CRI funds statewide and/or with Department approval. Department approval is contingent upon statewide program cost effectiveness. The calculations included in the contract amounts used a blended ratio of **40.74%** non federal and **59.27%** federal. The conditions identified above apply only to the CIP II CRI funding as long as it is identified with this CARS profile. The "approved Federal Medical Assistance Percentage (FMAP) rate" means the federal Medical Assistance percentages (FMAP) that are finalized and published in the federal register. The FMAP for the current federal fiscal year can be found on the Federal Register Website (www.federalregister.gov)

CIP II-Nursing Home Diversion Initiative (Profiles 374,375,376)
CIP II-Nursing Home Diversion Initiative expands the current CIP II Medicaid waiver for elders and people with physical disabilities through the expansion of relocations from

nursing homes under the CRI to include persons who are diverted from imminent entry into nursing homes. This initiative enables the Department to provide enhanced funding above the standard CIP II rate. Persons eligible for this program, in addition to meeting the usual functional and financial eligibility criteria for CIP II, must also meet specific risk criteria as defined by the Department. The Medicaid cost of serving individuals in the community under this initiative must be less than or equal to what the Medicaid costs would have been had the individuals been served in a nursing home. This program may be limited to a specified number of individuals if so determined by the Department. In addition, the number of persons served in this program at any one time may not exceed the number of "slots" as determined by the Department. Funding provided to a county under this initiative may be retained at the County level only if the county continues to use the funding for individuals eligible for the initiative. If an individual becomes ineligible for, or leaves, the initiative, the county may use the vacant "slot" for another eligible individual. Cost of the care plan for an individual may not exceed $85.00 per day. If the costs for an individual served in this initiative exceed $85.00 per day, the person must be moved to the County's CIP II/COP-W regular funding pool, and/or the person must be closed from this initiative. One-time expenses that exceed the $85.00 maximum require prior Department approval.

CIP II-Diversion Initiative: Non Federal Share of Reported Expenses **(Profile 375)**

CIP II-Diversion state Medicaid funds are available to reimburse counties for 100% of the allowable State's share of service costs for persons who have been diverted from a nursing home up to a maximum of $85.00 per day. By letter notice the Department may increase or decrease the number of CIP II-diversion slots allocated to the County. By letter notice the Department may increase the allowable care plan costs up to the maximum of $85.00 per day. The contract is the developed based on the number of persons awarded a NH diversion slot, times 365 service days, $85.00 per day, times the current state/federal ratio. The calculations for the contract amount used a blended ratio of **40.74%** non federal and **59.27%** federal.

Reimbursement of funds is based on actual expenses incurred during the calendar year. The non-federal share of diversion expense is contract controlled. Under the current process, the non-federal share of costs that exceed the contract amount will roll to CARS profile 561, the basic County allocation (BCA) for payment. The Department may reimburse diversion waiver expenses exceeding the contract maximum if sufficient dollars are available in the diversion waiver statewide and the person's cost of care does not exceed $85.00 per day per person. The county may not average costs within the slots awarded. COP regular funding **may not** be used to pay for expenses in excess of the diversion non federal contract amount. If the costs for an individual served in this initiative exceed the $85.00 per day, the person must be moved to the County's COP W/CIP II regular funding pool, and/or the person must be closed from this initiative. The conditions identified above apply only to the CIP II diversion funding as long as it is identified with this CARS profile.

CIP II-Diversion: Federal Share of Reported Expenses **(Profile 370)**

CIP II diversion federal Medicaid funds are available to reimburse counties for 100% of the allowable federal share of the CRI service costs. By letter notice the Department may increase or decrease the number of diversions allocated to the County. By letter notice the Department may increase the allowable care plan per diem for individuals up to a maximum of $85.00 per day. The above amount is based on the calculation of diversion slots times 365 days of service, times the average daily rate per day for each individual, times the current state/federal ratio. Reimbursement of funds is based on actual

expenses incurred during the calendar year. The federal portion of reported costs will be reimbursed for all waiver-allowable costs up to a maximum of $85.00 per day. The calculations included in the contract amounts used a blended ratio of **40.74%** non federal and **59.27%** federal. The Department may reimburse diversion waiver expenses exceeding the contract maximum if sufficient dollars are available in the diversion waiver statewide and the cost of the individual does not exceed $85.00 per day. The conditions identified above apply only to the CIP II diversion funding identified with this CARS profile. The Federal matching rate in effect means the federal Medical Assistance percentages (FMAP) that are finalized and published in the federal register. The FMAP for the current federal fiscal year can be found on the Federal Register Website. (www.federalregister.gov)

III. Fiscal Conditions on Earning of the Additional Funds

Earning of waiver funds requires an individual service plan approved by the Department for each participant as specified in ss.46.27 (11) or 46.27(7). These additional funds may be used only for community-based services for persons eligible for COP W/CIP II (including the CIP II Family Care Transfer funds, CRI and special nursing home diversion funds) and may only be used for those approved services specifically outlined and defined in the MA Community Waivers Manual. The persons served must reside in a private home/apartment, foster home; a community-based residential facility allowed under Wisconsin Statutes Section 46.27(11) and 46.27(7) or a certified Residential Care Apartment Complex. Unless waived by the individual participant, case management **must** be provided to all COP W/CIP II regular, CIP II Family Care transfer, CIP II-CRI and CIP II-diversion participants according to the case management contact requirements outlined in the MA Waivers Manual. Funds may not be earned when case management is required but is not provided. Funds are not earned for any day a participant is an inpatient in a hospital, SNF, ICF, or ICF-MR. MA-Waiver costs shall be calculated as the total of all allowable waiver expenses minus the applicable client share.

For **COP-W** cases, state funding is allocated to be used as Medicaid matching funds for the COP-W federal earned revenue. Federal funding is earned for approved waiver service costs incurred, at the applicable FMAP rate. If the allocation is less than the match needed for reimbursement of federal funds, the difference must be provided by the County from Sub-allocation B of the Community Options Program, or another source of allowable Medicaid match. When the COP-W non-federal matching funds are exhausted, the federal portion of additional approved COP-W service plan expenses may be claimed providing the County has other funds available for match. Unexpended COP-W GPR match may be carried over in the general COP budget to the extent allowable under COP carryover provisions in ss. 46.27(7) (fm). The Department shall apply these conditions in reconciling funds earned under the contract.

For **CIP II** cases, funding earned is comprised of federal and state Medicaid dollars and is 100% of the approved waiver service costs incurred, up to the maximum contract amount. For counties that exceed the CIP II waiver rate a variance may be granted. The County must provide match costs incurred in excess of the CIP II average daily rate from Sub-allocation B of the Community Options Program or other funds. The federal share of the excess funds will be reimbursed. The Department may permanently reduce the number of CIP II slots/days allocated to the County only by mutual consent between the County and the Department. Specific reporting and reimbursement requirements that vary from the regular CIP II program for the CIP II FCT, CIP II CRI and CIP II diversions are defined by the Department though the DDES (DLTC) memo series.

IV. Fiscal and Client Billing and Reporting Conditions

These additional funds and the clients served by them must be reported and billed to the Department as follows:

For each individual receiving services under an approved COP Waiver, CIP II, CIP II FCT, CRI and/or diversion service plan, expenditure information is required on the Human Services Reporting System (HSRS), or equivalent billing and reporting system approved by the Department, by the last day of the month following the month in which services are provided. If a county becomes two or more months behind in reporting on HSRS, the County will not be paid on CARS. Expenditures must be claimed based on date of service, not date of payment. All financial reports for the calendar year must be submitted no later than February 28 of the following year.

Calendar year expenditures will not be reimbursed for any individual receiving waiver services whose COP-W, CIP II, CIP II-FCT, CRI, or CIP II-diversion service plan packet has not been submitted to the Department or its designee by February 28 of the following year.

Because CIPII/COP-W is a Medicaid program, claims for individuals with invalid MA numbers will not be reimbursed.

Final year-end reconciliation of expenditures will be based on the information submitted on the HSRS, and/or equivalent billing and reporting system as determined by the Department. Any discrepancies between CARS reporting and HSRS and required state supplemental reporting forms will result in an adjustment to CARS at year-end. Information submitted on the HSRS must include but is not limited to, all services expenditures and associated units by the correct standard program category by participant. Information submitted on HSRS cannot include agency administrative expenses. Administrative expenses must be reported separately during the year-end reconciliation process.

All CIP II and COP-W expenses for allowable services including those incurred above the contract rates must be reported and billed on the HSRS waiver module or Department approved equivalent. All expenses for waiver allowable services for COP-W cases must be reported and billed on the DMT Form 600, Profile Line #337. All expenses for waiver allowable services for CIP II cases must be reported and billed on the DMT Form 600, Profile Lines #347, #368, #374, or #391 as applicable.

Failure to report expenditures of these funds for clients served by them as specified above will result in the loss of these funds by the County and their repayment by the County to the Department.

As the COP-W/CIP II programs transition into managed long term care, a county's COP-W/CIP II program allocations will be reduced to reflect that individuals are no longer being served under the COP-W/CIP II program; and instead are being served through the Family Care Program.

V. Payment Procedures

Payment shall be made in accordance with the State/County contract.

Payments through 6/30/2013 are limited to 6/12th of the contract with the balance paid after 06/30/2013 based on reported costs up to the contract level for the NON Fed profiles.